260.30 Service areas; selection and payment of health care providers and health care networks. (1) ESTABLISHMENT OF AREAS WHERE SERVICES WILL BE PROVIDED. The board may establish areas in the state, which may be counties, multicounty regions, or other areas, for the purpose of receiving bids from health care networks. These areas shall be established so as to maximize the level and quality of competition among health care networks or to increase the number of provider choices available to eligible persons and participants in the areas.

(2) OPTIONS AVAILABLE IN EACH AREA. In each area designated by the board under sub. (1), the board shall offer both of the following options for delivery of health care services under the plan:

(a) An option, known as the "fee-for-service option," under which participants must choose a primary care provider, may be referred by the primary care provider to any medical specialist, and may be admitted by the primary care provider or specialist to any hospital or other facility, for the purpose of receiving the benefits provided under this chapter. Under this option, the board, with the assistance of one or more administrators chosen by a competitive bidding process and with whom the board has contracted, shall pay directly, at the provider payment rates established by the board under sub. (7) (b) 1., for all health care services and articles that are covered under the plan.

(b) An option under which one or more health care networks that meet the qualifying criteria in sub. (4) and are certified under sub. (5) provide health care services to participants. The board is required to offer this option in each area designated by the board to the extent that qualifying health care networks exist in the area.

(3) SOLICITATION OF BIDS FROM HEALTH CARE NETWORKS. The board shall annually solicit sealed risk-adjusted premium bids from competing health care networks for the purpose of offering health care coverage to participants in one or more areas. The board shall request each bidder to submit information pertaining to whether the bidder is a qualifying health care network, as described in sub. (4).

(4) QUALIFYING HEALTH CARE NETWORKS. A health care network is qualifying if it does all of the following:

(a) Demonstrates to the satisfaction of the board that the fixed monthly risk-adjusted amount that it bids to provide participants with the health care benefits specified in this chapter reasonably reflects its estimated actual costs for providing participants with such benefits in light of its underlying efficiency as a network, and has not been artificially underbid for the predatory purpose of gaining market share.

(b) Will spend at least 92 percent of the revenue it receives under this chapter on one of the following:

1. Payments to health care providers in order to provide the health care benefits specified in this chapter to participants who choose the health care network.

2. Investments that the health care network has reasonably determined will improve the overall quality or lower the overall cost of patient care.

(c) Ensures all of the following:

1. That participants living in an area that a health care network serves shall not be required to drive more than 30 minutes, or, in a metropolitan area served by mass transit, spend more than 60 minutes using mass transit facilities, in order to reach the offices of at least 2 primary care providers, as defined by the board.

2. That physicians, physician assistants, nurses, clinics, hospitals, and other health care providers and facilities, including providers and facilities that specialize in mental health services and alcohol or other drug abuse treatment, are conveniently available, as defined by the board, to participants living in every part of the area that the health care network serves.

(d) Ensures that participants have access, 24 hours a day, 7 days a week, to a toll-free hotline and help desk that is staffed by persons who live in the area and who have been fully trained to communicate the benefits provided under this chapter and the choices of providers that participants have in using the health care network.

(e) Ensures that each participant who chooses the health care network selects a primary care physician who is responsible for overseeing all of the participant's care.

(f) Will provide each participant with medically appropriate and high-quality health care, including mental health services and alcohol or other drug abuse treatment, in a highly coordinated manner.

(g) Emphasizes, in its policies and operations, the promotion of healthy lifestyles; preventive care, including early identification of and response to high-risk individuals and groups, early identification of and response to health disorders, disease management, including chronic care management, and best practices, including the appropriate use of primary care, medical specialists, medications, and hospital emergency rooms; and the utilization of continuous quality improvement standards and practices that are generally accepted in the medical field.

(h) Has developed and is implementing a program, including providing incentives to providers when appropriate, to promote health care quality, increase the transparency of health care cost and quality information, ensure the

confidentiality of medical information, and advance the appropriate use of technology.

(i) Has entered into shared service agreements with out-of-network medical specialists, hospitals, and other facilities, including medical centers of excellence in the state, through which participants can obtain, at no additional expense to participants beyond the normally required level of cost sharing, the services of out-of-network providers that the network's primary care physicians selected by participants have determined is necessary to ensure medically appropriate and high-quality health care, to facilitate the best outcome, or, without reducing the quality of care, to lower costs.

(j) Has in place a comprehensive, shared, electronic patient records and treatment tracking system and an electronic provider payment system.

(k) Has adopted and implemented a strong policy to safeguard against conflicts of interest.

(L) Has been organized by physicians or other health care providers, a cooperative, or an entity whose mission includes improving the quality and lowering the cost of health care, including the avoidance of unnecessary operating and capital costs arising from inappropriate utilization or inefficient delivery of health care services, unwarranted duplication of services and infrastructure, or creation of excess capacity.

(m) Agrees to enroll and provide the benefits specified in this chapter to all participants who choose the network, regardless of the participant's age, sex, race, religion, national origin, sexual orientation, health status, marital status, disability status, or employment status, except that a health care network may do one of the following:

1. Limit the number of new enrollees it accepts if the health care network certifies to the board that accepting more than a specified number of enrollees would make it impossible to provide all enrollees with the benefits specified in this chapter at the level of quality that the network is committed to maintaining, provided that the health care network uses a random method for deciding which new enrollees it accepts.

2. Limit the participants that it serves to a specific affinity group, such as farmers or teachers, that the health care network has certified to the board, provided that the limitation does not involve discrimination based on any of the factors described in this paragraph and has neither been created for the purpose, nor will have the effect, of screening out higher-risk enrollees. This subdivision applies only to affinity groups that are in existence as of December 31, 2007.

(5) CERTIFICATION OF HEALTH CARE NETWORKS AND CLASSIFICATION OF BIDS. (a) The board shall review the bids submitted under sub. (3), the information submitted by bidders pertaining to whether the bidders are qualifying health care networks, and other evidence provided to the board as to whether a particular bidder is a qualifying health care network.

(b) Based on the information about bidder qualification submitted or otherwise provided under par. (a), the board shall certify which health care networks are qualifying health care networks.

(c) With respect to all health care networks that the board certifies under par. (b), the board shall open the submitted, sealed bids at a predetermined time. The board shall classify the certified health care networks according to price and quality measures after comparing their risk-adjusted per-month bids and assessing their quality. The board shall classify the network that bid the lowest price as the

lowest-cost network, and shall classify as a low-cost network any network that has bid a price that is close to the price bid by the lowest-cost network. Any other network shall be classified as a higher-cost network.

(6) OPEN ENROLLMENT. The board shall provide an annual open enrollment period during which each participant may select a certified health care network from among those offered, or a fee-for-service option. Coverage shall be effective on the following January 1. A participant who does not select a certified health care network or a fee-for-service option will be assigned randomly to one of the networks that have been classified under sub. (5) as having submitted the lowest or a low bid and as performing well on quality measures. A participant who selects a certified health care network that has been classified as a higher-cost network but who fails to pay the additional payment under sub. (7) (a) 2., shall be assigned randomly to one of the networks that has been classified under sub. (5) as the lowest-cost network or as a low-cost network and as performing well on quality measures, or to the fee-for-service option if that is the lowest-cost option.

(7) PAYMENTS TO NETWORKS AND PROVIDERS. (a) *Payments to health care networks.* 1. On behalf of each participant who selects or has been assigned to a certified health care network that has been classified under sub. (5) (c) as the lowest-cost network or a low-cost network and as performing well on quality measures, the board shall pay monthly to the health care network the full risk-adjusted per-member per-month amount that was bid by the network. The dollar amount shall be actuarially adjusted for the participant based on age, sex, and other appropriate risk factors determined by the board. A participant who selects or is assigned to the lowest-cost network or a low-cost network shall not be required to pay any additional amount to the network.

2. If a participant chooses instead to enroll in a certified health care network that has been classified under sub. (5) (c) as a higher-cost network, the board shall pay monthly to the chosen health care network an amount equal to the bid submitted by the network that the board classified under sub. (5) (c) as the lowest-cost network and as having performed well on quality measures. The dollar amount shall be actuarially adjusted for the participant based on age, sex, and other appropriate risk factors determined by the board. A participant who chooses to enroll in a higher-cost network shall be required to pay monthly, in addition to the amount paid by the board, an additional payment sufficient to ensure that the chosen network receives the full price bid by that network.

3. The board may retain a percentage of the dollar amounts established for each participant under subds. 1. and 2. to pay to certified health care networks that have incurred disproportionate risk not fully compensated for by the actuarial adjustment in the amount established for each eligible person. Any payment to a certified health care network under this subdivision shall reflect the disproportionate risk incurred by the health care network.

(b) *Payments to fee-for-service providers.* 1. The board shall establish provider payment rates that will be paid to providers of covered services and articles that are provided to participants who choose the fee-for-service option under sub. (2) (a). The payment rates shall be fair and adequate to ensure that this state is able to retain the highest quality of medical practitioners. The board shall limit increases in the provider payment rate for each service or article such that any increase in per person spending under the plan does not exceed the national rate of medical inflation.

2. Except for copayments, coinsurance, and any other cost sharing required or authorized under the plan, a provider of a covered service or article shall accept as

#20 and for purposes of payments for covered services and articles to which a deductible applies,

deductibles,

payment in full for the covered service or article the payment rate determined under subd. 1. and may not bill a participant who receives the service or article for any amount by which the charge for the service or article is reduced under subd. 1.

3. The board, with the assistance of its actuarial consultants, shall establish the risk-adjusted cost of the fee-for-service option offered to participants under sub. (2) (a). The board shall classify the fee-for-service option in the same manner that the board classifies certified health care networks under sub. (5) (c).

4. If the board has determined under sub. (5) (c) that there is at least one certified low-cost health care network in an area, which may be the lowest-cost health care network, and if the fee-for-service option offered in that area has not been classified as a low-cost choice under subd. 3., the cost to a participant enrolling in the fee-for-service option shall be determined as follows:

a. If there are available to the participant 3 or more certified health care networks classified under sub. (5) (c) as low-cost networks, or as the lowest-cost network and 2 or more low-cost networks, the participant shall pay the difference between the cost of the lowest-cost health care network and the risk-adjusted cost established under subd. 3. for the fee-for-service option, except that the amount paid may not exceed $100 per month for an individual, or $200 per month for a family, as adjusted for medical inflation.

b. If there are available to the participant 2 certified health care networks classified under sub. (5) (c) as low-cost networks, or as the lowest-cost network and one low-cost network, the participant shall pay the difference between the cost of the lowest-cost health care network and the risk-adjusted cost established under subd. 3. for the fee-for-service option, except that the amount paid may not exceed $65 per

month for an individual, or $125 per month for a family, as adjusted for medical inflation.

c. If there is available to the participant only one certified health care network classified under sub. (5) (c) as a low-cost network, or as the lowest-cost network, the person shall pay the difference between the cost of the lowest-cost health care network and the risk-adjusted cost established under subd. 3. for the fee-for-service option, except that the amount paid may not exceed $25 per month for an individual, and $50 per month for a family, as adjusted for medical inflation.

6. If the board has determined, under sub. (5) (c), that there is no certified lowest-cost health care network or low-cost health care network in the area, there shall be no extra cost to the participant enrolling in the fee-for-service option.

(8) INCENTIVE PAYMENTS TO FEE-FOR-SERVICE PROVIDERS. Health care providers and facilities providing services under the fee-for-service option under sub. (2) (a) shall be encouraged to collaborate with each other through financial incentives established by the board. Providers shall work with facilities to pool infrastructure and resources; to implement the use of best practices and quality measures; and to establish organized processes that will result in high-quality, low-cost medical care. The board shall establish an incentive payment system to providers and facilities that comply with this subsection, in accordance with criteria established by the board.

(9) PHARMACY BENEFIT. The board shall assume the risk for, and pay directly for, prescription drugs provided to participants. In implementing this requirement, the board shall replicate the prescription drug buying system developed by the group insurance board for prescription drug coverage under the state employee health plan under s. 40.51 (6), unless the board determines that another approach would be more

NO ¶ Except for prescription drugs to which a deductible applies, the ¶ NO

cost-effective. The board may join the prescription drug purchasing arrangement under this chapter with similar arrangements or programs in other states to form a multistate purchasing group to negotiate with prescription drug manufacturers and distributors for reduced prescription drug prices, or to contract with a 3rd party, such as a private pharmacy benefits manager, to negotiate with prescription drug manufacturers and distributors for reduced prescription drug prices.

260.35 Subrogation. The board and authority are entitled to the right of subrogation for reimbursement to the extent that a participant may recover reimbursement for health care services and items in an action or claim against any 3rd party.

260.37 Employer-provided health care benefits. Nothing in this chapter prevents an employer, or a Taft-Hartley trust on behalf of an employer, from paying all or part of any cost sharing under s. 260.20 or 260.30, or from providing any health care benefits not provided under the plan, for any of the employer's employees.

260.40 Assessments, individuals and businesses. (1) DEFINITIONS. In this section:

(a) "Department" means the department of revenue.

(b) "Eligible individual" means an individual who is eligible to participate in the plan, other than an employee or a self-employed individual.

(c) "Employee" means an individual who has an employer.

(d) "Employer" means a person who is required under the Internal Revenue Code to file form 941.

(e) "Self-employed individual" means an individual who is required under the Internal Revenue Code to file schedule SE.

(f) "Social security wages" means:

1. For purposes of sub. (2) (a), the amount of wages, as defined in section 3121 (a) of the Internal Revenue Code, paid to an employee by an employer in a taxable year, up to a maximum amount that is equal to the social security wage base.

2. For purposes of sub. (2) (b), the amount of net earnings from self-employment, as defined in section 1402 (a) of the Internal Revenue Code, received by an individual in a taxable year, up to a maximum amount that is equal to the social security wage base.

3. For purposes of sub. (3), the amount of wages, as defined in section 3121 (a) of the Internal Revenue Code, paid by an employer in a taxable year with respect to employment, as defined in section 3121 (b) of the Internal Revenue Code, up to a maximum amount that is equal to the social security wage base multiplied by the number of the employer's employees.

(2) INDIVIDUALS. Subject to sub. (4), the board shall calculate the following assessments, based on its anticipated revenue needs:

(a) For an employee who is under the age of 65, a percent of social security wages that is at least 2 percent and not more than 4 percent.

(b) For a self-employed individual who is under the age of 65, a percent of social security wages that is at least 9 percent and not more than 10 percent.

(c) For an eligible individual, who has no social security wages under sub. (1) (f) 1. or, from an employer, under sub. (1) (f) 3., 10 percent of federal adjusted gross income, up to the maximum amount of income that is subject to social security tax.

(3) EMPLOYERS. Subject to sub. (4), the board shall calculate an assessment, based on its anticipated revenue needs, that is a percent of aggregate social security wages that is at least 9 percent and not more than 12 percent.

(4) COLLECTION AND CALCULATION OF ASSESSMENTS. (a) For taxable years beginning after December 31, 2008, the department shall impose on, and collect from, individuals the assessment amounts that the board calculates under sub. (2), either through an assessment that is collected as part of the income tax under subch. I of ch. 71, or through another method devised by the department. For taxable years beginning after December 31, 2008, the department shall impose on, and collect from, employers the assessment amounts that the board calculates under sub. (3), either through an assessment that is collected as part of the tax under subch. IV of ch. 71, or through another method devised by the department. Section 71.80 (1) (c), as it applies to ch. 71, applies to the department's imposition and collection of assessments under this section.

(b) The amounts that the department collects under par. (a) shall be deposited into the Healthy Wisconsin trust fund under s. 25.775.

(c) The board may annually increase or decrease the amounts that may be assessed under subs. (2) and (3). No annual increase under this paragraph may exceed the percentage increase for medical inflation unless a greater increase is provided for by law.

260.49 Advisory committee. (1) DUTIES. The board shall establish a health care advisory committee to advise the board on all of the following:

(a) Matters related to promoting healthier lifestyles.

(b) Promoting health care quality.

(c) Increasing the transparency of health care cost and quality information.

(d) Preventive care.

(e) Early identification of health disorders.

(f) Disease management.

(g) The appropriate use of primary care, medical specialists, prescription drugs, and hospital emergency rooms.

(h) Confidentiality of medical information.

(i) The appropriate use of technology.

(j) Benefit design.

(k) The availability of physicians, hospitals, and other providers.

(L) Reducing health care costs.

(m) Any other subject assigned to it by the board.

(n) Any other subject determined appropriate by the committee.

(2) MEMBERSHIP. The board shall appoint as members of the committee all of the following individuals:

(a) At least one member designated by the Wisconsin Medical Society, Inc.

(b) At least one member designated by the Wisconsin Academy of Family Physicians.

(c) At least one member designated by the Wisconsin Hospital Association, Inc.

(d) One member designated by the president of the Board of Regents of the University of Wisconsin System who is knowledgeable in the field of medicine and public health.

(e) One member designated by the president of the Medical College of Wisconsin.

(f) Two members designated by the Wisconsin Nurses Association, the Wisconsin Federation of Nurses and Health Professionals, and the Service Employees International Union.

(g) One member designated by the Wisconsin Dental Association.

(h) One member designated by statewide organizations interested in mental health issues.

(i) One member representing health care administrators.

(j) Other members representing health care professionals. >>

#. Page 1353, line 13: after that line insert:

"SECTION 77. 285.59 (1) (b) of the statutes is amended to read:

285.59 **(1)** (b) "State agency" means any office, department, agency, institution of higher education, association, society, or other body in state government created or authorized to be created by the constitution or any law ~~which~~ that is entitled to expend moneys appropriated by law, including the legislature and the courts, the Wisconsin Housing and Economic Development Authority, the Bradley Center Sports and Entertainment Corporation, the University of Wisconsin Hospitals and Clinics Authority, the Fox River Navigational System Authority, the Wisconsin Aerospace Authority, ~~and~~ the Wisconsin Health and Educational Facilities Authority, and the Healthy Wisconsin Authority. >>

#. Page 1497, line 21: after that line insert:

"SECTION 78. 609.01 (7) of the statutes is repealed.

SECTION 79. 609.10 of the statutes is repealed.

SECTION 80. 609.20 (1m) (c) of the statutes is repealed.

SECTION 81. 609.20 (1m) (d) of the statutes is repealed. >>

"SECTION 82. 628.36 (4) (a) (intro.) of the statutes is amended to read:

628.36 **(4)** (a) (intro.) The commissioner shall provide information and assistance to ~~the department of employee trust funds,~~ employers and their employees, providers of health care services, and members of the public, as provided in par. (b), for the following purposes:

SECTION 83. 628.36 (4) (b) 1. of the statutes is repealed.

SECTION 84. 628.36 (4) (b) 2. of the statutes is repealed.

#. Page 1499, line 25: after that line insert:

SECTION 85. 628.36 (4) (b) 3. of the statutes is repealed.

SECTION 86. 632.87 (5) of the statutes is amended to read:

632.87 **(5)** No insurer ~~or self-insured school district, city or village~~ may, under a policy, plan, or contract covering gynecological services or procedures, exclude or refuse to provide coverage for Papanicolaou tests, pelvic examinations, or associated laboratory fees when the test or examination is performed by a licensed nurse practitioner, as defined in s. 632.895 (8) (a) 3., within the scope of the nurse practitioner's professional license, if the policy, plan, or contract includes coverage for Papanicolaou tests, pelvic examinations, or associated laboratory fees when the test or examination is performed by a physician.

SECTION 87. 632.895 (8) (f) 4. of the statutes is created to read:

632.895 **(8)** (f) 4. A disability insurance policy providing only health care benefits not provided under the Wisconsin Health Care Plan under ch. 260.

SECTION 88. 632.895 (9) (d) 4. of the statutes is created to read:

632.895 **(9)** (d) 4. A disability insurance policy providing only health care benefits not provided under the Wisconsin Health Care Plan under ch. 260.

SECTION 89. 632.895 (10) (a) of the statutes is amended to read:

632.895 **(10)** (a) Except as provided in par. (b), every disability insurance policy ~~and every health care benefits plan provided on a self-insured basis by a county board under s. 59.52 (11), by a city or village under s. 66.0137 (4), by a political subdivision under s. 66.0137 (4m), by a town under s. 60.23 (25), or by a school district under s. 120.13 (2)~~ shall provide coverage for blood lead tests for children under 6 years of age, which shall be conducted in accordance with any recommended lead screening methods and intervals contained in any rules promulgated by the department of health and family services under s. 254.158.

SECTION 90. 632.895 (10) (b) 6. of the statutes is created to read:

632.895 **(10)** (b) 6. A disability insurance policy providing only health care benefits not provided under the Wisconsin Health Care Plan under ch. 260.

SECTION 91. 632.895 (11) (a) (intro.) of the statutes is amended to read:

632.895 **(11)** (a) (intro.) Except as provided in par. (e), every disability insurance policy~~, and every self-insured health plan of the state or a county, city, village, town or school district,~~ that provides coverage of any diagnostic or surgical procedure involving a bone, joint, muscle, or tissue shall provide coverage for diagnostic procedures and medically necessary surgical or nonsurgical treatment for the correction of temporomandibular disorders if all of the following apply:

SECTION 92. 632.895 (11) (c) 1. of the statutes is amended to read:

632.895 **(11)** (c) 1. The coverage required under this subsection may be subject to any limitations, exclusions, or cost-sharing provisions that apply generally under the disability insurance policy ~~or self-insured health plan~~.

SECTION 93. 632.895 (11) (d) of the statutes is amended to read:

632.895 **(11)** (d) Notwithstanding par. (c) 1., an insurer ~~or a self-insured health plan of the state or a county, city, village, town or school district~~ may require that an insured obtain prior authorization for any medically necessary surgical or nonsurgical treatment for the correction of temporomandibular disorders.

SECTION 94. 632.895 (11) (e) 3. of the statutes is created to read:

632.895 **(11)** (e) 3. A disability insurance policy providing only health care benefits not provided under the Wisconsin Health Care Plan under ch. 260.

SECTION 95. 632.895 (14) (b) of the statutes is amended to read:

632.895 **(14)** (b) Except as provided in par. (d), every disability insurance policy~~, and every self-insured health plan of the state or a county, city, town, village or school~~

~~district,~~ that provides coverage for a dependent of the insured shall provide coverage of appropriate and necessary immunizations, from birth to the age of 6 years, for a dependent who is a child of the insured.

SECTION 96. 632.895 (14) (d) 7. of the statutes is created to read:

632.895 **(14)** (d) 7. A disability insurance policy providing only health care benefits not provided under the Wisconsin Health Care Plan under ch. 260.

~~**SECTION 97. Nonstatutory provisions.**~~

(1) WISCONSIN HEALTH CARE PLAN.

(a) *Legislative findings.* In establishing the Wisconsin Health Care Plan under chapter 260 of the statutes, as created by this act, the legislature finds all of the following:

1. 'Costs.' Health care costs in Wisconsin are rising at an unsustainable rate making the need for comprehensive reform urgent. Rising costs are seriously threatening the ability of Wisconsin businesses to globally compete; farms to thrive; government to provide needed services; schools to educate; and local citizens to form new and successful business ventures. Some indicators of rising costs are the following:

a. Total health care spending in Wisconsin in 2007 is projected to be $42.3 billion, and is projected to grow 82 percent, to $76.9 billion, in the next decade.

b. The cost of employer-provided health care in Wisconsin increased by 9.3 percent in 2006, averaging $9,516 per employee. This figure is 26 percent more than the national average.

c. Employee premium contributions and out-of-pocket costs are rising faster than wages.

d. Rising costs have led to a decline in employer-provided health benefits. In 1979, 73 percent of private-sector Wisconsin workers had employer-based health insurance coverage; however, only 57 percent received health benefits in 2004.

e. At least one-half of all personal bankruptcies in the United States are the result of medical expenses. Over 75.7 percent of this group had insurance at the onset of illness. In 2004, there were 13,454 medical bankruptcies in Wisconsin affecting 37,360 people.

f. The costs of health services provided to individuals who are unable to pay are shifted to others. Of the $22 billion charged by hospitals in 2005, $736,000,000 was not collected. Those who bear the burden of this cost shift have an increasingly difficult time paying their own health care costs.

2. 'Access.' There is a large and increasing number of people who have no health insurance or who are underinsured. For this growing population, health care is unaffordable and, most often, not received in the most timely and effective manner. Some indicators of lack of access to health care are as follows:

a. Over one 500,000 Wisconsin residents were uninsured at any given point during 2007.

b. Over 65 percent of the uninsured in Wisconsin are employed.

c. The uninsured are less likely to seek care and, thus, have poorer health outcomes compared to the insured population.

d. In 2007, total spending on the uninsured in Wisconsin is projected to reach over $1,000,000,000. About 23.2 percent of this amount will be in the form of uncompensated care; 21.7 percent will be provided through public programs; and 37.5 percent will be paid by the uninsured individuals.

3. 'Inequity.' The health care system contains inequities. Some indicators of inequity are as follows:

a. Wisconsin businesses are competing on an uneven playing field. The majority of Wisconsin businesses that do insure their workers are subsidizing those businesses that are not paying their fair share for health care.

b. Our current system forces the sick and the aging to pay far higher premiums than the healthy and those covered under group plans, rather than spreading the risk across the broadest pool possible.

c. The uninsured face medical charges by hospitals, doctors, and other health care providers that are 2.5 times what public and private health insurers pay.

4. 'Inefficiency.' Wisconsin does not have a clearly defined, integrated health care system. Our health care system is complex, fragmented, and disease-focused rather than health-focused, resulting in massive inefficiencies and placing inordinate administrative burdens on health care professionals. Some indicators of inefficiency are as follows:

a. Health care financing is accomplished through a patchwork of public programs, private sector employer-sponsored self-insurance, commercial insurance, and individual payers. The most recent study for Wisconsin estimates that about 27 cents of every health care dollar is spent on marketing, overhead, and administration, leaving only 73 cents left to deliver medical care.

b. This fragmentation and misaligned financial incentives lead, in some instances, to excessive or inadequate care and create barriers to coordination and accountability among health care professionals, payers, and patients.

c. The Institute of Medicine estimates that between 30 cents and 40 cents of every health care dollar is spent on costs of poor quality — overuse, underuse,

misuse, duplication, system failures, unnecessary repetition, poor communication, and inefficiency. Included in this inefficiency are an unacceptable number of adverse events attributable to medical errors. Patients receive appropriate care based on known "best practices" only about one-half of the time.

d. The best care results from the conscientious, explicit, and judicious use of current best evidence and knowledge of patient values by well-trained, experienced clinicians.

5. 'Limitations on reform.' Federal laws and programs, such as Medicaid, Medicare, Tri-Care, and Champus, constrain Wisconsin's ability to establish immediately a fully integrated health care system.

6. 'Wisconsin as a laboratory for the nation.' Wisconsin is in a unique position to successfully implement major health care reform. Many providers are already organized into comprehensive delivery systems and have launched innovative pilot programs to improve both the quality and efficiency of their care. Wisconsin is at the forefront in developing systems for health information transparency. Organizations such as the Wisconsin Collaborative for Healthcare Quality, Wisconsin Health Information Organization, and the Wisconsin Hospital Association have launched ambitious projects to provide data on quality, safety, and pricing.

(b) *Initial terms of Healthy Wisconsin Authority board.* Notwithstanding the lengths of terms of the members of the board of the Healthy Wisconsin Authority specified in section 260.05 (1) of the statutes, as created by this act, the initial members shall be appointed for the following terms:

1. One member each from section 260.05 (1) (a), (b), and (g) of the statutes, as created by this act, for terms that expire on July 1, 2009.

2. One member each from section 260.05 (1) (a), (b), and (e) of the statutes, as created by this act, for terms that expire on July 1, 2010.

3. One member each from section 260.05 (1) (c), (e), and (g) of the statutes, as created by this act, for terms that expire on July 1, 2011.

4. One member each from section 260.05 (1) (d), (f), and (g) of the statutes, as created by this act, for terms that expire on July 1, 2012.

5. One member each from section 260.05 (1) (a) and (b) of the statutes, as created by this act, for terms that expire on July 1, 2013.

6. One member each from section 260.05 (1) (a) and (b) of the statutes, as created by this act, for terms that expire on July 1, 2014.

(c) *Provisional appointments.* Notwithstanding the requirement for senate confirmation of the appointment of the members of the board of the Healthy Wisconsin Authority under section 260.05 (1) of the statutes, as created by this act, the initial members may be provisionally appointed by the governor, subject to confirmation by the senate. Any such appointment shall be in full force until acted upon by the senate, and when confirmed by the senate shall continue for the remainder of the term, or until a successor is chosen and qualifies. A provisional appointee may exercise all of the powers and duties of the office to which such person is appointed during the time in which the appointee qualifies. Any appointment made under this subsection that is withdrawn or rejected by the senate shall lapse. When a provisional appointment lapses, a vacancy occurs. Whenever a new legislature is organized, any appointments then pending before the senate shall be referred by the president to the appropriate standing committee of the newly organized senate.

→ #. Page 1688, line 13: after last line insert:

SECTION 98. Effective dates. This act takes effect on the day after publication, except as follows:

(1) WISCONSIN HEALTH CARE PLAN. The treatment of sections 13.94 (1) (dj) and (1s) (c) 5., 16.004 (7d) and (7h), 40.05 (4) (a) 4., (ag) (intro.), (ar), (b), and (be) and (4g) (d), 40.51 (1), (2), (7), (8), and (8m), 40.52 (1) (intro.), (1m), and (2), 40.98 (2) (a) 1., 49.473 (2) (c), 49.68 (3) (d) 1., 49.683 (3), 49.685 (6) (b), 49.686 (5), 59.52 (11) (c), 60.23 (25), 66.0137 (4), (4m) (b), and (5), 109.075 (9), 111.70 (1) (dm) and (4) (cm) 8s., 111.91 (2) (pt), 120.13 (2) (b) and (g), 149.12 (2) (em), 609.01 (7), 609.10, 609.20 (1m) (c) and (d), 628.36 (4) (a) (intro.) and (b) 1., 2., and 3., 632.87 (5), and 632.895 (8) (f) 4., (9) (d) 4., (10) (a) and (b) 6., (11) (a) (intro.), (c) 1., (d), and (e) 3., and (14) (b) and (d) 7. of the statutes, the renumbering and amendment of sections 40.51 (6) and 62.61 of the statutes, and the creation of sections 40.51 (6) (b) and 62.61 (1) (b) of the statutes take effect on January 1, 2009.

(END)

d-note

* INSERTS OUT OF ORDER

Insert 2-12

#. Page 5, line 6: before "or 279" insert "s. 260,".

(end ins 2-12)

Insert 3-5

#. Page 7, line 20: before "or 279" insert "s. 260,".

(end ins 3-5)

Insert 3-18

#. Page 16, line 19: after "Authority," insert "the Wisconsin Healthy Authority,".

(end ins 3-18)

Insert 4-6

#. Page 25, line 6: before "or 279" insert "s. 260,".

Page 25, line 11: before "or 279" insert "s. 260,".

Page 25, line 17: before "and 279" insert "s. 260,".

(end ins 4-6)

Insert 5-13

#. Page 26, line 2: after "Remediation Authority," insert "the Wisconsin Healthy Authority,".

(end ins 5-13)

Insert 5-22

Page 26, line 22: before "or 279" insert "s. 260,".

Page 29, line 18: before "or 279" insert "260,".

(end ins 5-22)

Insert 6-14

Page 30, line 11: before "or 279" insert "260,".

Page 34, line 9: before "or 279" insert "260,".

Page 34, line 19: before "or 279" insert "260,".

Page 35, line 18: before "or 279" insert "260,".

Page 38, line 5: before "or 279" insert "260,".

INSERT 6-14 CONT.

Page 42, line 1: after "Authority," insert NO ¶ "the Healthy Wisconsin Authority,".

Page 42, line 13: after "Authority," insert NO ¶ "the Healthy Wisconsin Authority,".

Page 43, line 7: after "Authority," insert NO ¶ "the Healthy Wisconsin Authority,".

Page 43, line 15: after "Authority," insert NO ¶ "the Healthy Wisconsin Authority,".

Page 43, line 22: after "Remediation Authority," insert NO ¶ "the Healthy Wisconsin Authority,".

Page 44, line 10: after "Authority," insert NO ¶ "the Healthy Wisconsin Authority,".

Page 44, line 18: after "Authority," insert NO ¶ "the Healthy Wisconsin Authority,".

Page 44, line 22: after "Authority," insert NO ¶ "the Healthy Wisconsin Authority,".

#. Page 45, line 6: after "Authority," insert "the Healthy Wisconsin Authority Authority,".

Page 45, line 11: after "Authority," insert "the Healthy Wisconsin Authority Authority,".

Page 45, line 16: after "Authority," insert "the Healthy Wisconsin Authority Authority,".

Page 45, line 20: after "Authority," insert "the Healthy Wisconsin Authority Remediation Authority,".

Page 48, line 7: before "or 279" insert "260,". ✓

Page 48, line 23: before "or 279" insert "260,". ✓

(end ins 6-14)

Insert 28-8

Page 1310, line 4: before "or 279" insert "260,". ✓

(end ins 28-8)

Insert 20-11

#. Page 762, line 18: after that line insert:

"SECTION 7641r. (8)

RP; 49.665(5)(ag) ".

(and Insert 20-11)

INSERT 39-20

(2) DEDUCTIBLES. (a) *Maximum amounts and who must pay.* 1. Subject to subd. 2., during any year, a participant who is 18 years of age or older on January 1 of that year shall pay a deductible of $300, which shall apply to all covered services and articles.

2. During any year, a family consisting of 2 or more participants who are 18 years of age or older on January 1 of that year shall pay a deductible of $600, which shall apply to all covered services and articles.

3. During any year, a participant who is under 18 years of age on January 1 of that year shall not be required to pay a deductible.

4. Except for copayments and coinsurance, the plan shall provide a participant with full coverage for all covered services and articles after the participant has received covered services and articles totaling the applicable deductible amount under this paragraph, regardless of whether the participant has paid the deductible amount.

(b) *Provider requirements.* 1. A provider that provides to a participant a covered service or article to which a deductible applies shall charge the participant for the service or article the payment rate established by the board under sub. (7) (b) 1. s. 260.30

2. Except for prescription drugs, a provider may not refuse to provide to a participant a covered service or article to which a deductible applies on the basis that the participant does not pay, or has not paid, any applicable deductible amount before the service or article is provided.

3. A provider may not charge any interest, penalty, or late fee on any deductible amount owed by a participant unless the deductible amount owed is at least 6 months past due and the provider has provided the participant with notice of the interest, penalty, or late fee at least 90 days before the interest, penalty, or late fee payment is due. Interest may not exceed ~~one~~ 1 percent per month, and any penalty or late fee may not exceed the provider's reasonable cost of administering the unpaid bill.

(c) *Adjustments by board.* Notwithstanding par. (a) 1. and 2., the board may adjust the deductible amounts specified in par. (a) 1. and 2., but only to reduce those amounts.

(END OF INSERT 39-20)

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRBb0471/1dn
RAC&PJK:...

Senator Erpenbach:

We have put together a preliminary draft of the Wisconsin Health Care Plan (WHCP). This draft is based on Laura Rose's Legislative Council draft, WLC-0107/8, modified per her instructions to create the WHCP. The Legislative Council draft captures well your policy decisions regarding the structure and operation of the WHCP and our aim in this preliminary draft is to incorporate these policy decisions into the statutes in a clear and legally effective manner. In carrying out this task, our preliminary draft seeks to harmonize the establishment of the WHCP with current law, so as to ensure that there are no statutory conflicts between the establishment and operation of the WHCP and the current duties of Wisconsin employers relating to the provision of health care coverage for their employees. In addition, because the WHCP is based, in part, on past proposed legislation that had both public and private attributes, we have tried to bring some conceptual consistency to the organizational structure and operation of WHCP. In preparing this preliminary draft, we have endeavored to prepare the very best draft we can given your time constraints. In reviewing the draft, please note the following:

1. Per your specific request, we have incorporated legislative findings and statements of intent in the draft. As we have discussed with your staff, at best, legislative findings and statements of intent have no legal effect, but, at worst, they may have a legal effect that you do not intend. For example, one of the goals of the health care plan is to cover every Wisconsin resident, but the list of eligible persons under the plan does not include every Wisconsin resident. Which controls: the specification of who is eligible under the plan or the stated goal of covering every resident? We have tried to account for this by making the attainment of the goal subject to other law. But, in a larger sense, we would advise not having such findings and statements of intent in law. The statements contain a bold vision for health care coverage in Wisconsin, but they may result in legal confusion.

2. Since we are giving the Legislative Audit Bureau the duty to perform a financial audit of the Healthy Wisconsin Authority (HWA) under s. 13.94 (1) (dj), there is no reason to also create s. 13.94 (1) (q).

3. Per Laura's instructions, with a couple of exceptions, we have used the governor's HWA provisions in 2007 Senate Bill 40 as the basis for dealing with HWA coverage across the statutes.

4. There is no need to specify that the HWA is subject to subchs. II and IV of ch. 19, since it would be included automatically under s. 19.32 (1).

5. Section 260.05 (4) (f) requires the HWA board to "Establish an independent and binding appeals process for resolving disputes over eligibility and other determinations made by the board." What does this mean? Does this mean that no one can ever go to court over an eligibility or determination disputes under the plan? As a state actor, the HWA can always be taken to court over state and federal constitutional issues, as well as under federal law. We are unsure if this one sentence gets you what you want.

6. In s. 260.05 (4) (j), we required the board to audit health care networks and providers. The proposed text had this audit and a provision that only allowed payment to the networks and providers after the audit. This would have required the networks and providers to provide "free" services for a while until the audit is complete. Let us know if you want the proposed text or the text we drafted. (We are making these kinds of decisions on our own at this juncture only because of the time constraints imposed on the production of the draft.)

7. In 16.004 (7d), the secretary of administration is given sweeping authority to contain health care costs in this state by rule. This power is potentially boundless, affecting every aspect of the delivery of health care in this state. It is unclear how this power will be exercised in practice and how it will interrelate with other statutory provisions that regulate the delivery of health care in this state.

8. In s. 260.20 (3) (b), a participant must pay coinsurance if receiving health care services from a specialist without a referral from his or her "care coordinator." A participant who chooses the "fee-for-service option" must choose a "primary care provider." Health care networks must ensure that participants select a "primary care physician" to oversee his or her care. If these are all the same entity, it would be preferable to use the same term to avoid confusion. Must the care coordinator be a "physician" if the person chooses a network but may be a "provider" and not necessarily a "physician" if the person chooses the fee-for-service option?

9. As you requested, s. 49.665 (5) (ag) is repealed in this draft. As a result, no one with coverage under BadgerCare will pay for the cost of that coverage in accordance with the schedule established by DHFS. My understanding is that this was done so that no employee with coverage under BadgerCare would have to pay for BadgerCare coverage and the assessment under WHCP, also. The repeal of s. 49.665 (5), however, is much broader than that. It would be preferable to exclude from the assessment any person who is not eligible for WHCP.

10. Is s. 260.30 (7) drafted consistently with your intent? It appears that health care networks submit bids with respect to one or more areas; however, it is unclear how they are classified. I assumed that a health care network was classified with respect to the area or areas for which its bid was submitted. In that case, by definition, if only one health care network is certified for an area, that health care network is the lowest-cost one. Therefore, the only way an area would not have a lowest-cost network is if no networks were certified for the area. Is that your intent?

11. Because WHCP provides comprehensive coverage, covers all employees, and requires all employees and all employers to pay assessments to cover the cost of WHCP, employers that provided health care coverage for their employees before WHCP goes into effect will discontinue their own health care plans. In this way, although WHCP does not directly affect employer-provided employee benefit plans, WHCP indirectly "relates to an employee benefit plan." Whether the effect is substantial enough for the legislation to be preempted by ERISA can only be answered by a court, and then only if legal action were brought to have that determination made.

12. Section 260.40 requires the HWA board to determine the assessment rates for employers and employees and then to have the Department of Revenue (DOR) impose the assessments. It could be argued that the HWA is essentially determining the assessments entirely on its own and is only using DOR as the means to collect the assessments. In other words, the assessing entity is essentially an authority and not the "state" or a state agency. To our knowledge, the HWA would be the only authority in Wisconsin with this kind of power—that is, the power to assess without "state" approval of the assessment or tax rate. This could become an issue if for any reason a court would find that the HWA is not the "state" for the purpose of making an assessment. To make certain that the "state" is actually making these assessments, you could have the HWA board submit the proposed assessment rates to the Department of Administration or another state agency for approval before DOR is required to impose and collect the assessments.

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(1) Allow for judicial review of the board determinations

(2) Pg. 21, line 21 – have a board of trustees

(3) Pg 26, line 21: delete authority to issue bonds, etc. under (m)

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRBb0471/1dn
RAC&PJK:jld:pg

June 19, 2007

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Suggested Chronic Care Language
(Modified from Vermont legislation)

Add to goals section

is to achieve a unified, comprehensive, statewide system of care that improves the lives of Vermonters with or at risk for chronic disease.

* * * Chronic Care Management and Prevention * * *

DEFINITIONS

(2) "Chronic care" means health services provided by a health care professional for an established disease that is expected to last a year or more and that requires ongoing clinical management attempting to restore the individual to highest function, minimize the negative effects of the disease, and prevent disease-related complications. Examples of chronic disease include diabetes, hypertension, cardiovascular disease, cancer, asthma, pulmonary disease, substance abuse, mental illness, and hyperlipidemia.

(3) "Chronic care management" means a system of coordinated health care interventions and communications for individuals with chronic disease, including significant patient self-care efforts, systemic supports for the physician and patient relationship, emphasis on the significant role of the primary care provider in coordinating care and a plan of care emphasizing prevention of complications utilizing evidence-based practice guidelines, patient empowerment strategies, and evaluation of clinical, patient and economic outcomes on an ongoing basis with the goal of improving overall health.

(4) "Health risk assessment" means screening by a health care professional for the purpose of assessing an individual's health, including tests or physical exams and a survey or other tool used to gather information about an individual's health, medical history, and health risk factors during a health screening.

(5) "Patient registry" means an electronic database of patient information including diagnoses of chronic diseases.

(6) "Health care professional" means an individual, partnership, corporation, facility, or institution licensed or certified or authorized by law to provide professional health care services.

(7) "Primary Care Provider" means a physician, certified nurse practitioner or physicians assistant identified as the key professional responsible for coordinating all medical care for a given patient including referral to any specialist. Primary care providers include general practice physicians, family practitioners, internists, pediatricians, obstetricians and gynecologists, certified nurse practitioners, certified nurse midwives, and physician assistants. Primary care providers may also include specialists who are treating 1) a person with a chronic medical condition or special health care needs

for which regular treatment by a specialist is medically necessary; or 2) a disabled person, as defined (by law elsewhere?).

COMPONENTS OF A CHRONIC DISEASE MANAGEMENT PROGRAM

Each network receiving certification from the trust and each Fee for Service Network qualifying for incentive bonus payments shall have operational a Chronic Disease Management Program that includes the following components:

(1) a method involving the health care professional in identifying eligible patients, including the use of the patient registry, an enrollment process which provides incentives and strategies for maximum patient participation, and a standard statewide health risk assessment for each individual;

(2) a process for identifying a primary care provider and assuring that provider is coordinating patient care among health care professionals;

(3) methods of increasing communication among health care professionals and patients, including patient education, self-management, and follow-up plans;

(4) educational, wellness, and clinical management protocols and tools used by the health care providers, including management guideline materials for health care professionals to assist in patient-specific recommendations;

(5) process and outcome measures to provide performance feedback for health care professionals and information on the quality of care, including patient satisfaction and health status outcomes;

(6) For Qualifying Networks only (refer to section on qualifying networks) – the network shall create payment methodologies for primary care providers which create financial incentives and rewards for health care professionals to improve disease management and the quality of care, including case management fees or pay for performance payments to the care management organization which would guarantee net savings to the state or put the care management organization's fee at risk if the management is not successful in reducing costs to the state.;

(7) For Fee for Service Networks only (refer to section – the Trust shall reimburse primary care providers for their work in coordinating care and shall provide payment methodologies which create financial incentives and rewards for health care professionals to improve disease management and the quality of care, including case management fees or pay for performance; and

DISCRETION IN IMPLEMENTATION

With the goal of including all individuals, the board may initially target the requirements for chronic care management programs to individuals with certain disease diagnoses to ensure successful implementation and quality of services and to maximize cost savings. In accepting qualifying bids, the board may provide a time period for implementing chronic care management to allow sufficient time for health care professionals to identify and enroll individuals with chronic diseases.

Kahler, Pam

From: Rose, Laura
Sent: Wednesday, June 20, 2007 1:33 PM
To: Kahler, Pam
Cc: Johnson, Kelly
Subject: Kelly Johnson comments

Pam, see message below from Kelly regarding the dental issue. No dental coverage at all for adults; preventive dental ONLY for kids under 18, with no cost sharing.

And on page 33: For the covered services or articles in this provision for which there is a deductible, the charge is what the board determines is applicable under the network plan, NOT the fee for service plan.

Please let me know if you have any questions.

THANKS!!!!!!!!!!

Laura

From: Johnson, Kelly
Sent: Wednesday, June 20, 2007 1:28 PM
To: Rose, Laura
Subject: RE: How to reach me

Really quickly Laura, I made a couple of mistakes.
1. we do not cover dental for adults at all, so we were wrong on that section…so it is only preventive dental for under age 18….
2. pg. 33 line 6-9 can you please have lrb craft language that will read that the people are subject to the network rates instead of the FFS rates.
Thanks!

From: Rose, Laura
Sent: Wednesday, June 20, 2007 1:23 PM
To: Champagne, Rick; Kahler, Pam; Shovers, Marc
Cc: Johnson, Kelly
Subject: How to reach me

Hi everyone,

I am going to work at home for the rest of the afternoon. This is one of the weeks this summer that my 12 year old daughter has nothing going on. . .so I'd like to supervise her if possible. Please, don't have any hesitation to call me with any questions at all. I'll bring my file home with me. And, I will be at the office tomorrow.

My home # is 238-4386; my cell # is: 334-9111.

Thanks,

Laura

Kahler, Pam

From: Johnson, Kelly
Sent: Wednesday, June 20, 2007 1:48 PM
To: Kahler, Pam
Cc: Haber, Darcy
Subject: One last thing

Regarding pg. 33 Ln 6-9: Providers are subject to the network rates if they are in the network and the fee for service rates if they are in a fee for service plan.
Thank you!